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# DEPARTMENT OF HEALTH AND HUMAN RESOURCES
# DIVISION OF CHILD AND FAMILY SERVICES

## CHILD FATALITY ANALYSIS (CLARK COUNTY) – December 1, 2005

### *Introduction/Background:*

Regional Child Death Review (CDR) teams are organized and operational in Nevada based on Nevada Revised Statutes (NRS) chapter 432B, section 403 through 409. Assembly Bill 381, passed by the 2003 Nevada Legislature, allowed for the implementation of significant changes in the child death review process, establishing the Executive Committee and Administrative Team to review child fatalities. Members of the child welfare agencies participate on the Executive Committee and Administrative Team.

Assembly Bill 1, as passed by the 2001 17th Special Legislative Session, permitted the transfer (or, integration) of child welfare services from the state Division of Child and Family Services (DCFS) to a county whose population is 100,000 or more. Transition of programs to Washoe County started in April 2002 and was completed in January 2003. Transfer of state staff to Clark County began in October 2003 and was completed in October 2004, concluding the state and local integration process. Integration has had an impact on the child death review process, creating three jurisdictions for review of child fatalities within the child welfare/child protective system. Collaboration among the child welfare agencies, regional CDR teams, the Executive Committee and Administrative Team has evolved over the last two years into the establishment of a review system dependent upon one another for the development of recommendations related to law, policy and practice changes, staff training and public education based on data from child death reviews. The primary goal of this collaboration is to prevent future child maltreatment and fatalities.

***Child Fatality Reporting:***

DCFS is required to provide child fatality information for inclusion into a variety of state and federal reports. An information system, the Child Abuse and Neglect Data System (CANS), is used to compile report information and is maintained by DCFS. Reports to be completed that rely on this data are: the state's annual Child Death Report, submitted by the Executive Committee to Review the Death of Children; the annual report of Child Abuse and Neglect Statistics, submitted by DCFS; and the Child Maltreatment Report compiled by the federal Administration for Children and Families (ACF). Child fatalities due to child maltreatment are reported to ACF, and the data is used systemically to measure the impact and effectiveness of child protective services through performance measure outcomes.

In January 2005, the state DCFS requested, and the county child welfare agencies began providing, voluntary "courtesy death notifications" on open child welfare/child protective services cases. On May 3, 2005, a memorandum of understanding (MOU) was executed between the state DCFS, Washoe County Department of Social Services and Clark County Department of Family Services (CCDFS). The MOU established an agreement that courtesy notifications would be submitted to the state agency, DCFS, within 24 hours of a county child welfare agency Director or DCFS Rural Region Manager learning of a child fatality in which an open child welfare or child protective services case or child welfare system involvement existed within the past two years. For the purposes of this document, "child welfare system" encompasses child protective services, foster care services and all out-of-home placements, including shelter care, placements with relatives, and adoptive or independent living placements.

***Need for Child Fatality Analysis:***

In 2002, Nevada reported three (3) child fatalities due to maltreatment to the federal ACF. This data was included in the 2003 Child Maltreatment Report;

published by ACF, it is the most current state-to-state comparative report available.

Based on this reported data, Nevada's child fatality due to maltreatment was 0.52 deaths per 100,000 children. The lowest fatality rate published was 0.00/100,000 (reported by Delaware and North Dakota). The highest fatality rate published was 7.67/100,000 (reported by West Virginia). The national average published was 2.00/100,000.

After implementing the courtesy death notifications process in January 2005, the number of notices received in the first six months of the process exceeded the entire number of fatalities reported in 2002. The need for a longitudinal analysis was apparent.

Further, in July 2005 and October 2005, the regional office of the federal ACF in San Francisco sent four letters to the state DCFS, requesting that investigations be completed, based on "news reports" of child deaths allegedly due to maltreatment. A fifth letter was received in November 2005.

***Data Analysis Methods:***

To facilitate development of an accurate accounting of child fatalities, the following action has been completed by DCFS:

- A detailed database of child fatalities in Clark County, 2001 through 2004, has been developed with source data from: CANS; Unified Nevada Information Technology for Youth (UNITY); the courtesy death notifications database; and regional CDR team data.
- Substantiations through prior and post-death CANS entries have been reviewed; currently open UNITY cases, prior CPS involvement, and prior state juvenile justice system involvement and/or prior mental health system involvement has been assessed.

- The DCFS source data has been cross-checked with state death records to evaluate initial data quality and identify areas needing improvement within the data collection process.

The data analysis did not include a review of Clark County paper files, nor interviews with individual caseworkers. The purpose of the initial data analysis was not intended to review case practice. The intent of the data analysis was to determine as accurately as possible: total child fatalities; fatalities of children currently being served (or previously being served) by the programs established to help protect children from maltreatment; the accuracy of reporting systems; and whether child fatalities are being classified appropriately.

***Preliminary Data Analysis Findings:***

- 1,041 children died during the five-year study period. Approximately 63% died from "natural/other" causes. Approximately 37% died from causes such as homicide, asphyxia, drowning and accidents, according to Nevada health records.
- Of all child fatalities, 35 were previously substantiated as abuse or neglect. Upon analysis, 79 additional cases have the potential of being related to maltreatment, and should be reviewed.
- 45 of those 231 fatalities of children known to the system occurred while there was a child protective services case open for the child/family. This is approximately 20%. Many of these deaths were not due to maltreatment.
- 11 children died while in the custody of the state/county and in an out-of-home placement (i.e., foster care, relatives, shelters, hospitals).
- The data analysis shows an increasing number of child deaths involving maternal drug use. The data reported in this area for 2003-2004 is significantly higher than that reported for 2001-2002.
- Initial analysis of the data further indicates that Nevada has been under-reporting child fatalities in previous state/federal reports, based upon the reporting and recording of data in the CANS. The state reported total

statewide child deaths due to maltreatment reported in 2002 was three (3). Records indicate that Clark County alone substantiated seven (7) cases of abuse/neglect, and with further file reviews, more deaths could be substantiated as due to child maltreatment. There is no evidence of any deliberate under-reporting based on this initial data analysis.

- Child fatality information has not been entered timely or consistently into record systems such as UNITY and CANS. Additionally, conflicting information exists between the systems.
- Communication gaps exist among medical, law enforcement and child welfare systems; deaths are not uniformly defined and classified.
- Statewide, often when a child dies from maltreatment, and there are no siblings or other children in the home, no child protective services investigation is warranted, per state regulations. Further, these deaths are often not reported in the UNITY or CANS systems, and therefore are not included in state/federal death reports. Other agencies have investigated these deaths; however, communication needs to be improved among all agencies.

***Next Steps:***

An external formal case review of child fatalities will be conducted by a panel of independent experts who will assess and provide an objective analysis of selected cases to identify trends and areas needing improvement. The panel will make recommendations consistent with NRS 432B.403 that support the safety of children and prevent child fatalities through: resource allocation realignment; improving data collection and quality improvement systems; re-evaluation of laws, policies, procedures, practices; staff training; and public education. The independent expert panel will use standardized case review instruments and child fatality review summary forms to record information and compile the review results. The independent expert panel will then analyze the case reviews and develop a report of their findings and recommendations.

The independent expert panel will be funded through the use of Victims of Crimes Assistance funding. State DCFS will issue a Request for Applications and convene the panel.

Additionally, a “blue ribbon review committee” will be established by the state and county child welfare agencies. The committee will oversee the external review process of the independent expert panel, will review the recommendations and work with the state and county to implement necessary change. The blue ribbon review committee will consist of five to seven members representing the law enforcement, medical/coroner, legal, education and child welfare disciplines.